AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS/MyVaxIndiana PIN

Hamilton County Health Department
Noblesville, Indiana 46060
Charles Harris, Health Officer

INSTRUCTIONS: *1. Complete* **ALL** *portions of this form.* **A printed copy of record will be sent unless #4 is checked.** *Designate to mail or fax below.*
2. Please sign and fax to (317)776-8506. Email requests are not accepted.
3. If you have any questions please call the Hamilton County Health Department at (317)776-8500 .
4. Requesting MyVaxIndiana PIN # **(for more information visit: www.myvaxindiana.in.gov)** *Yes: _____ No: _____*

Patient's Name: _____
(last name) (*first name)* (*middle name)*

Date of Birth: _____ Previous Name(s): _____

Parent/Guardian (released to parent/guardian only if child under 18 years of age):_____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Social Security Number***:** _____

I request and authorize the Hamilton County Health Department to release immunization information maintained in the Hamilton County Health Deparment Immunization/CHIRP database to the person or agency named below. Requested information will be faxed or mailed to the below designated fax number or address as soon as possible, but no later than 10 working days after receipt of this signed authorization.

Receiving agency or individual fax or mailing information. RECORDS CANNOT BE EMAILED DUE TO HIPAA
Please send Records/MyVaxIndiana PIN # by: Fax _____ Mail _____ OR Will Pick Up _____ Date _____

Person or agency to receive records: _____

Fax Number: ( )_____ Phone Number:( ) _____

Address: _____

City: _____ State: _____ ZIP Code: _____

This authorization expires 60 days after the date it is signed. A copy of this document is considered the same as the original.

I further understand that I may revoke this authorization at any time be notifying the releasing organization in writing, but if I do it will not have any effect on any actions that were taken before my revocation is received.

By signing this authorization, I acknowledge that I have read and understand this authorization. I understand that immunization records to be disclosed will be disclosed in accordance with this authorization.

I declare under the penalty of perjury under the laws of the State of Indiana that the foregoing is true and correct, and that I am authorized to sign this release on the patient's behalf.

Signed on _____ at _____
(month/day/year) *(city and state where signed)*

_____ _____
(signature of patient or parent/legal guardian if younger than 18 years) *(relationship to patient)*

** This Agency is requesting your Social Security Number in accordance with IC 4-1-8-1. Disclosure is voluntary and you will not be penalized for refusal.*

Notice: The Hamilton County Health Department keeps a record of immunizations entered into the Hamilton County or CHIRP database system. You may ask us for a copy of your record or your children's record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. To obtain your immunization record or PIN #, we recommend you first check with your provider's office. If they are unable to provide a copy of your complete immunization history, please contact the Hamilton County Health Department at (317) 776-8500. **For questions regarding MyVaxIndiana please contact the CHIRP or MyVaxIndiana Helpdesk at 1-888-227-4439 or by email at: chirp@isdh.in.gov OR MyVaxIndiana@isdh.in.gov.**